CONFIDENTIAL

STUDENT INJURY REPORT
(MEDICAL ATTENTION NEEDED)

NAME OF CHILD CARE PROGRAM _____ DATE OF INJURY_____

ADDRESS _____ TIME OF INJURY_____

NAME OF CHILD_____ AGE_____ SEX_____

NAME OF PARENT_____

ADDRESS_____

WAS INJURY CAUSED BY A FALL? YES_____ NO_____
IF YES, TYPE OF SURFACE_____

DID INJURY OCCUR ON PLAYGROUND EQUIPMENT? YES_____ NO_____
IF YES, TYPE OF EQUIPMENT_____

HOW DID THE INJURY HAPPEN? (DESCRIBE BRIEFLY)_____

_____

_____

WHERE DID INJURY OCCUR?_____

NAME OF STAFF MEMBER IN CHARGE_____
WAS HE/SHE PRESENT AT SCENE OF INJURY? YES_____ NO_____

WITNESS TO INJURY (IF ANY)_____

WAS CHILD GIVEN FIRST AID? YES_____ NO_____ BY WHOM_____

TYPE OF AID GIVEN?_____

WERE PARENTS NOTIFIED? YES_____ NO_____ BY WHOM_____

WHEN?_____

WAS EMERGENCY TREATMENT PROVIDED AT HOSPITAL/DR. OFFICE/DENTIST? YES_____ NO_____

WHERE?_____

RESULT OF INJURY (DIAGNOSIS/TREATMENT)_____

_____

CORRECTIVE ACTION TAKEN TO PREVENT FURTHER INJURIES_____

_____

SIGNATURE OF DIRECTOR_____ TODAY'S DATE_____

RETURN TO: DIVISION OF FAMILY RESOURCES
BUREAU OF CHILD CARE
402 WEST WASHINGTON STREET, RM W-386
INDIANAPOLIS, IN 46204

5/06